MOTION FILED
JUN 11 1992

(3)

No. 91-1813

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

R. Ernest COHN, D.C., D.A.B.C.O.,

Petitioner,

v.

John L. BOND, M.D., *et al.*,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

MOTION FOR LEAVE TO FILE ATTACHED BRIEF OF AMICUS CURIAE, THE AMERICAN CHIROPRACTIC ASSOCIATION, IN SUPPORT OF THE PETITION

GEORGE P. MCANDREWS
(Counsel of Record)
ROBERT C. RYAN
McANDREWS, HELD & MALLOY
500 West Madison Street
34th Floor
Chicago, Illinois 60661
(312) 707-8889

Counsel for Amicus Curiae

Midwest Law Printing Co., Chicago 60611, (312) 321-0220

No. 91-1813

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

R. Ernest COHN, D.C., D.A.B.C.O.,

Petitioner,

v.

John L. BOND, M.D., *et al.*,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

MOTION FOR LEAVE TO FILE ATTACHED BRIEF OF AMICUS CURIAE, THE AMERICAN CHIROPRACTIC ASSOCIATION, IN SUPPORT OF THE PETITION

Pursuant to Rule 37.4 of the Rules of this Court, the American Chiropractic Association ("ACA") moves for leave to file the following brief *amicus curiae* in support of present Petition for Writ of Certiorari. In support of this motion, the ACA states as follows:

1. As a national association of over 18,000 chiropractor members, the ACA is uniquely in the possession of facts and scientific research demonstrating the paramount importance of this case not just to its 18,000 chiropractor members and their millions of patients but to the entire nation as well.

2. As the ACA explains in the following brief, researchers have recognized that exclusionary conduct such as that presently before the Court (the exclusion of chiropractors from access to any hospital facilities) is the natural and intended result of national hospital accreditation standards promulgated by a medical-physician-dominated trade association (the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO")).

3. As the ACA also explains in its brief, the JCAHO standards, and their intended exclusions of competitors from hospitals, are widely recognized to be anticompetitive, to have nationwide impact, and to be a significant contributor to the healthcare cost crises facing the nation today.

4. The ACA also would like to present additional aspects of error in, and conflict among the circuits raised by, the decision in issue as brought to this Court by the Questions Presented.

The ACA thus requests leave to file the following brief in order to further demonstrate the importance of the Questions Presented to the entire nation and the need for this Court to grant this Petition.

Respectfully submitted,

GEORGE P. MCANDREWS
(Counsel of Record)
ROBERT C. RYAN
McANDREWS, HELD & MALLOY
500 West Madison Street
Chicago, Illinois 60661
(312) 707-8889

Counsel for Amicus Curiae

TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES	iv
I.	
THIS CASE INVOLVES CRITICALLY IMPORTANT HEALTHCARE ISSUES THAT WERE TREATED UNACCEPTABLY BELOW	1
II.	
THE EXCLUSION AT ISSUE IS NATIONWIDE AND ANTICOMPETITIVE BY DESIGN	3
III.	
THE COURT BELOW IMPROPERLY FAILED TO EVEN ACKNOWLEDGE THE EXPRESS STATE POLICY OF CHIROPRACTORS' ACCESS TO PUBLIC HOSPITALS	9
IV.	
THE CIRCUIT COURTS' ATTEMPTS TO APPLY *COPPERWELD* IN THE HOSPITAL SETTING HAVE CREATED CONFUSED AND INCONSISTENT INTERPRETATIONS OF INTRACORPORATE IMMUNITY	11
A. The Circuits Differ In Applying The Economic Unity Standard Within The Hospital Setting	11
B. The Circuits Also Disagree As To The Validity And Application Of The Independent Personal Stake Exception	13
CONCLUSION	15

TABLE OF AUTHORITIES

Cases PAGE

Bhan v. NME Memorial Hosp., 669 F.Supp. 998 (E.D.Cal. 1987), *aff'd*, 929 F.2d 1404 (9th Cir. 1991), *cert. denied*, ___ U.S. ___, 112 S.Ct. 617 (1991) 15 n.9

Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810 (11th Cir. 1990), *cert. denied*, 495 U.S. 924 (1990) 13 n.5

Cal. Retail Liquor Dealers Ass'n v. Midcal Alum., 445 U.S. 97 (1980) 9

Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984) 11, 14

Nanavati v. Burdette Tomlin Memorial Hosp., 857 F.2d 96 (3d Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989) 12 n.4

Nurse Midwifery Assoc. v. Hibbett, 918 F.2d 605 (6th Cir. 1990), *cert. denied*, ___ U.S. ___, 112 S.Ct. 406 (1991) 12 n.4, 14

Oksanen v. Page Memorial Hosp., 945 F.2d 696 (4th Cir. 1991) 14 n.6, 15 n.8

Oltz v. St. Peter's Community Hosp., 861 F.2d 1440 (9th Cir. 1988) 13 n.5

Parker v. Brown, 317 U.S. 341 (1943) 9

Pinhas v. Summit Health, Ltd., 894 F.2d 1024 (9th Cir. 1989), *cert. denied*, ___ U.S. ___, 111 S.Ct. 61 (1990) 12 n.3

Pink Supply Corp. v. Hiebert, Inc., 788 F.2d 1313 (8th Cir. 1986) 14 n.6

Southern Motor Carriers Rate Conf. v. United States, 471 U.S. 48 (1985) 9

State of Arizona v. Maricopa County Medical Society, 643 F.2d 553 (9th Cir. 1980), *rev'd*, 457 U.S. 332 (1982) 2, 6

Tunis Bros. Co. v. Ford Motor Co., 763 F.2d 1482 (3d Cir. 1985), *vacated*, 475 U.S. 1105 (1986), *original opinion reinstated*, 823 F.2d 49 (3d Cir. 1987), *cert. denied*, 484 U.S. 1060 (1988) 14 n.7

Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985) 12 n.3, 13

Wilk v. AMA, 671 F.Supp. 1465 (N.D. Ill. 1987), *aff'd*, 895 F. 2d 352 (7th Cir. 1988), *cert. denied*, 111 U.S. 913 (1990) 3, 4, 5, 6

Statutes

N.C. Gen. Stats. §§ 90-153, 90-157.1 ..... 2, 3, 10 n.1

N.C. Gen. Stat. § 131E-85(a) (1989) 3, 10 n.2

Others

AHA Analysis of JCAHO Revised Medical Staff Standards 26 (Am. Hosp. Ass'n 1984) 6

Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. Pa. L. Rev. 431 (1988) 7, 8

Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective*, 9 Am. J. L. & Med. 263 (1983) 7

Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071 7

Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care in the Public Interest*, 24 B.C. L. Rev. 835 (1983) 8

Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 Wis. L. Rev. 1 7

Meade, M.D., *Low Back Pain of Mechanical Origin: Randomized Comparison of Chiropractic and Hospital Treatment*, 300 *British Med. J.* 1430 (1990) 2

Rial, M.D., *AMA News* (Dec. 16, 1983) 5

Shekelle *et al.*, *The Appropriateness of Spinal Manipulation and for Low-Back Pain, Project Overview and Literature Review* 7 (Rand Corp. 1991) 2

Speech of AMA Trustee to AMA Membership 4 (Am. Med. Ass'n 1983) 6

No. 91-1813

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

R. Ernest COHN, D.C., D.A.B.C.O.,

Petitioner,

v.

John L. BOND, M.D., *et al.*,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF OF AMICUS CURIAE, THE AMERICAN CHIROPRACTIC ASSOCIATION, IN SUPPORT OF THE PETITION

I.

THIS CASE INVOLVES CRITICALLY IMPORTANT HEALTHCARE ISSUES THAT WERE TREATED UNACCEPTABLY BELOW.

The health care industry currently does not display significant competitive conditions. There are many reasons for this situation, including the tax laws, the effects of insurance, and, as the majority notes, government regulation and financial entanglement. It is also undoubtedly true that a major factor has been the active suppression of competition by traditional medical associations. The restraints fostered by these groups are and should be subject to conventional antitrust scrutiny.

State of Arizona v. Maricopa County Medical Society, 643 F.2d 553, 565-66 (9th Cir. 1980) (Larson, J., dissenting; citations omitted), *rev'd*, 457 U.S. 332 (1982). This case presents this Court with the opportunity to resolve important conflicts among the circuits while subjecting to traditional antitrust scrutiny a medical-association-orchestrated conspiracy to exclude chiropractors and others—in this case in direct conflict with the express will of the North Carolina State legislature. N.C. Gen. Stats. §§ 90-153, 90-157.1.

This Court's review is essential, particularly in view of the voluminous classical research demonstrating that chiropractors are not only more effective but also more efficient in treating musculo-skeletal problems (primarily those of the lower back). As a study conducted *by medical doctors* in Britain concluded:

> Chiropractic treatment [of low back pain of mechanical origin] was more effective than hospital [i.e., medical doctor managed] outpatient management, mainly for patients with chronic or severe back pain. . . . The potential economic, resource, and policy implications of our results are extensive. . . . Our results suggest that there might be a reduction of some 290,000 days in sickness absence [in Britain] during two years, saving about $21,580,000 in output and $4,814,000 in social security payments. . . . There is, therefore, economic support for use of chiropractic in low back pain, though the obvious clinical improvement in pain and disability attributable to chiropractic treatment is in itself an adequate reason for considering use of chiropractic [in hospitals].

Meade, M.D., *Low Back Pain of Mechanical Origin: Randomized Comparison of Chiropractic and Hospital Treatment*, 300 *British Med. J.* 1430 (1990). There are other studies, many by medical doctors, to the same effect. *E.g.*, Shekelle *et al.*, *The Appropriateness of Spinal Manipula-*

tion and for Low-Back Pain, Project Overview and Literature Review 7 (Rand Corp. 1991) (the literature supports use of spinal manipulation (chiropractic) to relieve acute low back pain without neurological involvement).

At the same time, it is beyond debate that the enormous and growing healthcare sector in this country is uncompetitive and consuming inordinate resources. The Fourth Circuit's decision nevertheless looked to a single North Carolina statute (N.C. Gen. Stats. § 131E-85(a)) as authority for immunization of blatantly anticompetitive conduct in the healthcare sector without even acknowledging additional aspects of the same statute, and other North Carolina statutes (N.C. Gen. Stats. §§90-153, 90-157.1), expressly providing to the contrary. The Fourth Circuit's effective nullification of these North Carolina state statutes is a costly mistake with nationwide repercussions.

II.

THE EXCLUSION AT ISSUE IS NATIONWIDE AND ANTICOMPETITIVE BY DESIGN.

In the present case, the local hospital's "executive committee" decided to exclude competitive chiropractors from access to any hospital facilities whatsoever. This is no unique arrangement or result; it is by the careful design of the governing hospital accreditation standards of the "Joint Commission on Accreditation of Healthcare Organizations" (JCAHO).

Since in or before 1982, the hospital in issue has been accredited by JCAHO, formerly called the "Joint Commission on Accreditation of Hospitals" (JCAH). The "JCAHO" has long been owned by five medical organizations: the American Medical Association (AMA); the American Hospital Association (AHA); the American College of Surgeons (ACS); the American College of Physicians (ACP);

and the American Dental Association (ADS). *Wilk v. AMA*, 671 F.Supp. 1465, 1489 (N.D. Ill. 1987), *aff'd*, 895 F.2d 352 (7th Cir. 1988), *cert. denied*, 111 U.S. 913 (1990). The JCAHO is governed by twenty-two commissioners appointed by their sponsoring organizations as follows: 7 by the AMA; 7 by the AHA; 3 by the ACP; 3 by the ACS; 1 by the ADA; and one other "public" member named by the other commissioners. *Id.*, 671 F.Supp. at 1489-90.

The JCAHO is thus a private trade association whose primary purpose is to promulgate and enforce standards for accreditation of hospitals. *Id.* JCAHO accreditation is "important to a hospital and loss of accreditation would be devastating." *Id.* It "can close a hospital." *Id.* JCAHO thus "has the power to define and regulate the activities which take place in hospitals and to eliminate or frustrate competition from non-medical physician health care providers." *Id.*

From in or before the 1960's until 1980, JCAHO interpreted its standards to require exclusion of chiropractors from any access to hospital facilities or personnel. *Id.* at 1490-91, 895 F.2d at 373. Following the AMA's lead, it was the JCAHO's widely published position that:

> The Commission looks on Doctors of Chiropractic as cultists. A hospital that encourages cultists to use its facilities in any way would very probably be severely criticized and lose its accreditation.

Id.

In 1970, at the request of the AMA, the JCAHO adopted the AMA's ethical standards ("Standard X"), which included a decades-old AMA ethics boycott of chiropractors. *Id.* "*[K]eeping chiropractors out of hospitals was one of the goals of the boycott.*" *Id.* JCAHO agents then repeatedly and consistently proceeded to advise hospitals "that

JCAH[O] would withdraw accreditation of a hospital that had chiropractors on its medical staff or that granted privileges to chiropractors." *Id.*

Four chiropractors brought the *Wilk* action against the AMA, the JCAHO, and a variety of other medical trade associations in 1976. *Id.* In response to the antitrust exposure, the JCAHO deleted Standard X four years later and proposed to its sponsoring associations that each hospital would be allowed to decide for itself whether to "credential" chiropractors, i.e., grant chiropractors access to hospital facilities. *Id.* The medical doctor membership of the sponsoring associations revolted and accused the AMA of failing to support its constituency—medical doctors. *Id.* The AMA then succumbed to this pressure and actively opposed the JCAHO proposal. *Id.*

The AMA then proposed a new standard requiring a hospital to have an "executive committee," the majority of which would have to be medical physicians and would be given sole authority to recommend and approve hospital credentialing for all healthcare providers within the hospital. *Id.* The JCAHO adopted this proposal, and the power of medical physicians to decide the competitive fate of chiropractors in hospitals was perpetuated. *Id.*

When the new standards were being adopted in 1983, the AMA announced to all AMA members:

> The JCAH must transfer the antitrust risk from the national level—where an adverse decision would apply to all hospitals—to the local level, and this is the way it should be done.

Rial, M.D., *AMA News* (Dec. 16, 1983).

> Let me [an AMA Trustee] assure you [the AMA membership] that we'll do all we possibly can to see to it that [the JCAHO standards provide that medical]

> physicians . . . both individually and collectively, as members of hospital medical staffs, will continue to be primarily responsible for [hospital] staff structure, credentials, privileges . . . ."

Speech of AMA Trustee to AMA membership, at 4 (1983).

The AHA later told its membership the same thing:

> [T]he revised standards also reflect a desire to keep ultimate control of the executive committee in the hands of the physician members of the medical staff.
>
> . . . .
>
> The revised standards also require that clinical privileges to admit patients be extended only to practitioners who are, or who become, members of the medical staff . . . .

AHA Analysis of JCAHO Revised Medical Staff Standards, pp. 26, 36 (1984).

The case before the Court involves exactly the type of medical physician exclusion of competitive healthcare providers that the JCAHO standards were designed to perpetuate. The JCAHO standards, which have long governed the hospital in issue, mandate that the hospital's credentialing decisions must be approved by the members of the medical-physician-dominated executive committee. *Wilk*, 895 F.2d at 374.

It is no surprise, therefore, that the Wilkes County Hospital executive committee voted to exclude competitive healthcare providers from all access to the hospital facility in which they would otherwise compete.

> Logic and common sense tell us that it is unreasonable to expect that a combination of medical providers might willingly take measures which could reduce their income and would require changes in the way they have traditionally conducted business.

Maricopa County, 643 F.2d at 568 (Larson, J., dissenting).

The commentators have nearly uniformly decried that this is the intended result of the JCAHO standards.

> JCAH standards decree an organized medical staff whose by-laws 'establish a framework for self-governance.' Notably the medical staff must have substantial authority over membership selection: it alone conducts the credentialing process that is the basis for determining admitting and treating privileges.

Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. Pa. L. Rev. 431, 529-30 (1988). It is in this manner that "Organized medicine's control over hospital privileges imposes the most direct limitation on non-physician practices." Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 Wis. L. Rev. 1, 9. *See also* Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1087, 1091 (the 1983 changes notwithstanding, the JCAHO standards remain the medical profession's vehicle of control over access to hospitals). As a result, "the consumer's 'free choice of physician,' so jealously guarded by professional interests through the years, has implied very little freedom to choose anything but a physician." Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective*, 9 Am. J. L. & Med. 263, 265, 268-69 (1983).

As the commentators have also frequently explained, this private arrangement is plainly anticompetitive and a likely contributor to the healthcare cost crises facing the nation today:

> [Medical] physicians, not institutions, control the vast bulk of health care expenditures. . . . Although difficult to quantify with precision, informed estimates

> place 70 to 90 percent of health care expenditures within the control of individual practitioners.
>
> . . . .
>
> Cost containment pressures will not relent until [medical] physicians have undergone a revolutionary change in behavior.
>
> . . . .
>
> For decades, physicians have enjoyed essentially unfettered control over both medical practice and its workplace. Physicians gained control of access to medical practice at the turn of the century through licensing laws and medical education requirements that created a self-perpetuating, state-sanctioned monopoly. During the following quarter of a century, the medical profession harnessed the hospital through accreditation standards that assured costless and unrestricted use of these capital intensive facilities essential to modern practice.
>
> . . . .
>
> The hospital industry, marked by a much greater degree of uniformity than other sectors of the economy, is particularly ripe for organizational innovation
>
> . . . .
>
> *The [medical] profession's grip on the internal organization of the hospitals must be broken in order for cost containment to succeed.*

Hall, 137 U. Pa. L. Rev. at 434, 445-46, 507 (emphasis added). *See also, e.g.*, Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care in the Public Interest*, 24 B.C. L. Rev. 835, 874, 876, 882, 909, 911, 923 (1983) ("JCAH[O] accreditation is a powerful tool for limiting competition against physicians in the hospital setting [and] may, by thus restraining competition, increase the cost of health care").

III.

THE COURT BELOW IMPROPERLY FAILED TO EVEN ACKNOWLEDGE THE EXPRESS STATE POLICY OF CHIROPRACTORS' ACCESS TO PUBLIC HOSPITALS.

The purpose of the state action doctrine is to shield activities directed by the state legislature from antitrust examination. *Parker v. Brown*, 317 U.S. 341, 350 (1943). The test of the state action doctrine is two pronged. "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself." *Cal. Retail Liquor Dealers Ass'n v. Midcal Alum.*, 445 U.S. 97, 105 (1980) (*quoting City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978)). The state action issue in this case centers around the first prong of this test, as the Fourth Circuit failed to adequately examine the state policy with regard to chiropractic access to hospitals.

Under the first prong, the criteria to determine the state's policy toward regulation of commerce is the state's intent to displace competition. *Southern Motor Carriers Rate Conf. v. United States*, 471 U.S. 48, 64 (1985). The state's intent can be found in statutes promulgated by the legislature. *See id.* at 64-65. If the State does not evince a clear intent to displace competition, then the state action exemption is not applicable. *Id.* at 64.

In this case, North Carolina's statutes not only fail to evince a clear intent to displace competition, but actually express a policy favoring competition. N.C. Gen. Stat.

§ 90-153 (1977)[1] clearly reflects the North Carolina legislature's intent to provide chiropractors full access to hospitals. Moreover, N.C. Gen. Stat. § 131E-85(a) (1989), in which the court below found an implicit displacement of chiropractic competition in hospitals, expressly provides that it does not "mandate" any such thing.[2] Thus, the repeatedly *stated* legislative intent of the North Carolina statutes favors the ability of chiropractors to have access to, and compete within, public hospitals. Any other interpretation nullifies the North Carolina state legislature's repeatedly expressed intent.

---

[1] N.C. Gen. Stat. § 90-153 provides:

Licensed chiropractors may practice in public hospitals

A licensed chiropractor in this State may have access to and practice chiropractic in any hospital or sanitarium in this State that receives aid or support from the public, and shall have access to diagnostic x-ray records and laboratory records relating to the chiropractor's patient.

[2] N.C. Gen. Stat. § 131E-85(a) provides:

The granting or denial of privileges to practice in hospitals to physicians licensed under Chapter 90 of the General Statutes, Article 1, dentists and podiatrists and the scope and delineation of such privileges shall be determined by the governing body of the hospital on a non-discriminatory basis. Such determinations shall be based upon the applicant's education, training, experience, demonstrated competence and ability, and judgment and character of the applicant, and the reasonable objectives and regulations of the hospital, including, but not limited to appropriate utilization of hospital facilities, in which privileges are sought. *Nothing in this Part shall be deemed to mandate hospitals to grant or deny to any such individuals or others privileges to practice in hospitals, or to offer or provide any type of care.* [Emphasis added.]

IV.

THE CIRCUIT COURTS' ATTEMPTS TO APPLY *COPPERWELD* IN THE HOSPITAL SETTING HAVE CREATED CONFUSED AND INCONSISTENT INTERPRETATIONS OF INTRACORPORATE IMMUNITY.

In *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 771-773 (1984), this Court considered the intracorporate antitrust immunity for a parent corporation acting in concert with its wholly owned subsidiary. The circuit courts have subsequently attempted to apply the intracorporate immunity doctrine to the hospital setting, resulting in rampant confusion and inconsistent holdings among them.

A. The Circuits Differ In Applying The Economic Unity Standard Within The Hospital Setting.

This Court originally looked to the "economic unity" of the parent-subsidiary relationship as the basis of intracorporate immunity. The Court held that "the ultimate interests of the subsidiary and the parent are identical, so the parent and the subsidiary must be viewed as a single economic unit." *Copperweld*, 467 U.S. at 772 n.18.

The lower courts, however, have inconsistently applied this definition of economic unity within the hospital setting. First, the courts below have applied different standards to determine when medical staff doctors conspire with each other (as opposed to conspiring with the hospital itself). In this regard, the courts have either:

(a) defined economic unity as *a lack of independent economic interests*, and since medical doctors are sepa-

rate economic entities with individual interests, they are never covered under the immunity doctrine;[3] or

(b) defined economic unity as *a lack of direct competition*, which can often provide independent medical doctors with immunity unless they directly compete with each other.[4]

Second, other lower courts have applied completely different standards to determine if and when a medical staff (as one unit) may conspire with the hospital itself (as a separate unit). Under these standards, the courts have either:

(a) defined economic unity as *a lack of independent economic interests* so that medical doctors as a group may conspire with a hospital when their goals are independent of the hospital's goals;[5] or

---

[3] "Any action taken by a medical staff satisfies the 'contract, combination or conspiracy' requirement." *Pinhas v. Summit Health, Ltd.*, 894 F.2d 1024, 1033 (9th Cir. 1989), *cert. denied*, ____ U.S. ____, 111 S.Ct. 61 (1990) (*construing Weiss v. York Hosp.*, 745 F.2d 786, 814-817 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985)).

[4] When the staff as a group makes decisions or recommendations for the hospital in areas that do not affect the market in which they compete as individuals, there is no reason not to treat them as agents of the hospital. However, when competing physicians are making privilege recommendations concerning another competitor, sufficient anticompetitive concerns are raised.

Nurse Midwifery Assoc. v. Hibbett, 918 F.2d 605, 614 (6th Cir. 1990), *cert. denied*, ____ U.S. ____, 112 S.Ct. 406 (1991). *See also Nanavati v. Burdette Tomlin Memorial Hosp.*, 857 F.2d 96, 119 (3d Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989).

[5] Although the M.D. anesthesiologists may have been the agents of St. Peter's for some purposes, their interests were not as wed as the ties between a corporation and its officers or employees. . . . Those interests were sufficiently independent so

(Footnote continued on following page)

(b) defined economic unity as *a lack of competition* between the hospital and its medical doctors or staff, and since "the [medical] staff as an entity [has] no interest in competing with the hospital," the staff has been held to be legally incapable of conspiring with the hospital. *Weiss*, 745 F.2d at 817.

Amicus submits that the standard for immunity should be the same in a hospital setting as it is anywhere else: intracorporate immunity should only apply where the actors have identical economic interests, as they do within a corporation. This Court should adopt a rule that medical doctors may conspire with each other when they are in fact separate economic entities having disparate economic interests that lack economic unity. Similarly, a medical staff (or its members) may conspire with a hospital when the staff is comprised, as it usually is, of non-employee medical physicians with independent economic interests. Such a holding would advance the cause of reduction of anticompetitive behavior, particularly in the highly anticompetitive and oligopolized healthcare sector. In any event, this area is rife with important and costly conflicts of law that are ripe for review by this Court.

B. The Circuits Also Disagree As To The Validity And Application Of The Independent Personal Stake Exception.

This Court has noted, without comment, that there is an independent personal stake exception to the intracor-

---

[5] *continued*

that the collaborated conduct between the anesthesiologists and St. Peter's coalesced economic power previously directed at disparate goals.

Oltz v. St. Peter's Community Hosp., 861 F.2d 1440, 1450 (9th Cir. 1988). *See also Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810, 819 (11th Cir. 1990), *cert. denied*, 495 U.S. 924 (1990).

porate immunity doctrine: "[M]any courts have created an exception for corporate officers acting on their own behalf." *Copperweld*, 467 U.S. at 769 n.15.

The circuits disagree over this exception. In particular, the circuit courts do not agree on whether there exists an exception to intracorporate immunity for those who are acting on their own behalf within the hospital setting.

For example, the Sixth Circuit does not recognize any personal stake exception:

> We are not convinced that an agent acting with anti-competitive motives due to some independent personal stake raises sufficient antitrust concerns to warrant abandoning the traditional rule that a principal cannot conspire with one of its agents.

Nurse Midwifery, 918 F.2d at 615.

Of those circuits recognizing the exception, there is confusion over what constitutes an "independent personal stake." Some circuits require a "direct economic benefit" to satisfy the exception,[6] while others allow various indirect benefits, such as loyalty or goodwill.[7] Additionally, some circuits require that the independent personal stake play a dominant role in the decision-making proc-

---

[6] "We construe 'for the agents own benefit' to mean at least an economic stake in the gain to be realized from the anticompetitive object of the conspiracy." *Pink Supply Corp. v. Hiebert, Inc.*, 788 F.2d 1313, 1318 (8th Cir. 1986). *See also Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 705 (4th Cir. 1991).

[7] "[T]heir personal motivation and stake was not monetary gain but the product of loyalty and allegiance . . . ." *Tunis Bros. Co. v. Ford Motor Co.*, 763 F.2d 1482, 1496 n.22 (3d Cir. 1985), *vacated*, 475 U.S. 1105 (1986), *original opinion reinstated*, 823 F.2d 49, 50 n.2 (3d Cir. 1987), *cert. denied*, 484 U.S. 1060 (1988).

ess,[8] while others recognize mere subordinate participation as adequate.[9]

Amicus submits that these conflicts demonstrate the need for review of the Fourth Circuit's decision and announcement of a single standard from this Court.

CONCLUSION

Amicus thus requests that the Court allow the ACA's motion for leave to file its brief, grant the Petition for Writ of Certiorari, and review the important questions presented by the Petition.

Respectfully submitted,

GEORGE P. MCANDREWS
(Counsel of Record)
ROBERT C. RYAN
McANDREWS, HELD & MALLOY
500 West Madison Street
34th Floor
Chicago, Illinois 60661
(312) 707-8889

Counsel for Amicus Curiae

---

[8] If the officer cannot cause a restraint to be imposed and his firm would have taken the action anyway, then any independent interest is largely irrelevant to antitrust analysis. *Oksanen*, 945 F.2d at 705.

[9] *See generally Bhan v. NME Memorial Hosp.*, 669 F.Supp. 998, 1016-1017 (E.D.Cal. 1987), *aff'd*, 929 F.2d 1404 (9th Cir. 1991), *cert. denied*, ____ U.S. ____, 112 S.Ct. 617 (1991).